BENEFIT CORRECTION REQUEST
State Form 52090 (3-05)

State of Indiana
State Personnel Department,
Benefits Division

Agency:	Contact Person:
Phone Number:	Email Address:
Employee Name:	PeopleSoft ID:

Issue Involves:
☐Health ☐Dental ☐Vision ☐Medical Spending Account ☐Dependent Care Spending Account
☐Basic Life Insurance ☐Supplemental Life Insurance ☐Dependent Life Insurance

Description of Issue:

Attach Supporting Documentation, for example:

- Copy of most recent Benefit Statement or multiple statements if appropriate
- Copy of corresponding AS-47
- If applicable, copy of paper application on file
- If applicable, copy of student/disabled dependent certification

SPD ONLY
Note:

Date Received:	Date Resolved:	Initials